uterine cavity. The insertion of the ovum and its development seems to depend largely upon the place of impregnation. There was a distinct interval between impregnation and the permanent attachment of the ripe ovum. The nearer to the uterus in the tube impregnation occurs, the greater is the movement of the ovum in the uterus before it becomes permanently attached. Different conditions of the mucous membrane of the uterus have an influence upon the insertion of the ovum. Endometritis undoubtedly causes the death of many impregnated ova; while in other cases the ovum becomes attached to the lower portion of the uterus, which may be free from pathological lesions. Uterine myomas are often the indirect cause, through their accompanying endometritis, of placenta prævia. Above the internal os the placenta develops in the decidua capsularis, which forms the external envelope at its deepest portion, covering the os uteri, and becoming the lower portion of the placenta prævia. The nourishment of this portion of the placenta is obtained through the decidua, whose vessels obtain blood from the sinuses of the uterus. Adhesions between the capsular decidua and the decidua vera rarely occur at the opening of the Fallopian tubes, and also at the internal os. Should such union develop, it is easily separated by slight hemorrhage. The placenta does not firmly adhere at the internal os because of its development in the decidua. In the early months of gestation placenta prævia may give the symptoms of carcinoma of the body of the uterus. The low attachment of the ovum and placenta prævia frequently cause interruption of the pregnancy. Many spontaneous abortions arise from placenta prævia. The bleeding in these cases is caused by the separation of the capsular decidua from the decidua vera through dilatation of the os, which opens vessels in the capsular decidua which are in communication with the placental site. Later, partial separation of the placenta follows, or laceration of the placental tissue. The indications for treatment are to compress the bleeding vessels at the site of the placenta and dilate the cervix. In extreme cases total extirpation of the uterus by abdominal section may be indicated.

Induction of Labor with the Modified De Ribes Bag.—BRODHEAD (*Amer. Jour. Obstetrics*, May, 1912) reports 139 cases of induced labor, 75 being private patients and 64 hospital cases. The method of introducing the bag is as follows: The usual preparations having been made, a 1 per cent. lysol vaginal douche is given, and the cervix dilated with the finger and with a steel dilator sufficiently to permit the introduction of one of the bags. The bag is twisted, the base of the bag pulled out, and the bag rolled up and carefully passed by forceps into the cervix, either by inspection or vaginal touch, and slowly filled with a sterile solution of lysol or salt. For this purpose the writer has devised a glass syringe with a rubber plunger which can be readily sterilized. The ordinary Davidson syringe may be used. When the bag has been completely filled the stem is clamped and tied. As a rule no traction is made, unless dilatation must be rapid, when traction is made at intervals of ten or fifteen minutes. When the first bag is expelled through the cervix, if labor has not begun, a larger one is introduced. This is usually followed in a few hours by the beginning of active labor. Where the cervix is almost completely dilated by the bags without setting up active pains, the membranes may be ruptured, and if necessary delivery completed by forceps or version. Bags No. 2 and 3 were used in 73 per cent. of cases. In 41 cases labor was induced for contracted pelvis; in 27 for toxemia; in 19 for a large child; in 15 for overdue pregnancy; in 13 because the patient was at term and anxious to get through; and in 11 for a previous history of uterine inertia with instrumental delivery; in 4 cases the menbranes had ruptured without labor developing; the other cases were induced for unusual conditions. In 6 cases, or 3 per cent., the membranes were accidentally ruptured during the insertion of the bags; in 3 cases, or 10 per cent., labor failed to develop with the use of the bags. In 85 per cent. of the primiparæ who were private patients, the introduction of not more than two bags was sufficient to bring on labor. In 2 patients where the bags failed to cause pains, they softened the cervix, and when the membranes were ruptured labor developed. In 42 multiparæ who were private patients, more than one-half were delivered by the use of one bag only; about one-third required the use of two. In 4 multiparæ, or 9 per cent., the bags failed to produce labor. In approximately 83 per cent. of multiparæ who were private patients, labor was induced by the use of not more than two bags. In cases where the bags failed to induce labor the patients were delivered by version or forceps, and in these cases the bags softened and dilated the cervix. An anesthetic was necessary for inserting the bags in one-sixth of the cases. In private primiparous patients labor began at once in 45 per cent., within twelve hours in 73 per cent., and within thirty hours in 79 per cent. With the private multiparæ, labor immediately began in 22 per cent., within twelve hours in 63 per cent., within thirty hours in 85 per cent. If both private and hospital primiparæ are considered, labor began at once in 49 per cent., within twelve hours in 76 per cent., within thirty hours in 85 per cent. With the multiparae, immediate labor followed in 31 per cent., within twelve hours in 68 per cent., within thirty hours in 89 per cent. If all cases together are considered, immediate labor followed in 37 per cent., within twelve hours in 70 per cent., within thirty hours in 88 per cent. In all the primiparous patients, on an average eight hours and twenty-two minutes elapsed before labor developed; in all multiparous patients, ten hours and twenty-two minutes. The average for all patients was nine hours and forty-one minutes. The length of the induced labor averaged in primiparæ twenty-two hours and nine minutes; in multiparæ fifteen hours and fifty-two minutes; or in all, eighteen hours and two minutes. In all these cases 49 per cent. had normal labor, 21 per cent. low forceps, 11 per cent. medium forceps, 3 per cent. high forceps, 10 per cent. version, 3 per cent. breech extraction, 1 per cent. craniotomy, 1 per cent. Cesarean section, and 1 per cent. died without delivery. Among the 139 cases the use of the bags changed the presentation in 7, or 5 per cent. In only one of these cases was the outcome of the labor changed because of the use of the bag. Presentation or prolapse of the cord occurred in 6, or 4.3 per cent. In one case the bag slipped above the head, but labor developed and proceeded normally, and the bag was readily removed. There was practically no morbidity among the private patients, and but trifling morbidity among the hospital patients. The patient who died undelivered perished from eclampsia.